## **MENTAL STATUS & TREATMENT/PROGRESS REPORT**

IO INE ME	NIAL HEALTH CARE PROVIDER:
· -	] is applying for Medicaid Disability Benefits, or ] is currently receiving Benefits and his/her case is up for review.

THE MENTAL HEALTH CARE DROVIDED.

In order for us to evaluate this person's qualifications to receive benefits, we need medical evidence as to the nature of his/her condition, and the severity of the associated impairment.

## This form should be completed by the TREATING PHYSICIAN or therapist.

Please complete the form based on your knowledge of this individual, using existing treatment and progress records and results of previous evaluations, as well as current observations.

A narrative report, covering the following points, may be substituted instead of this form. **NOTE:** A history (from existing records) of treatment and progress, as well as a description of demonstrable signs and observations, is far more useful than a subjective report from the client.

**DO NOT** give the report to the client. **Return the completed report to the worker.** 

Worker's Name Title Department	Worker's Address	Worker's Phone #
Client's Name	Social Security Number	Client ID#

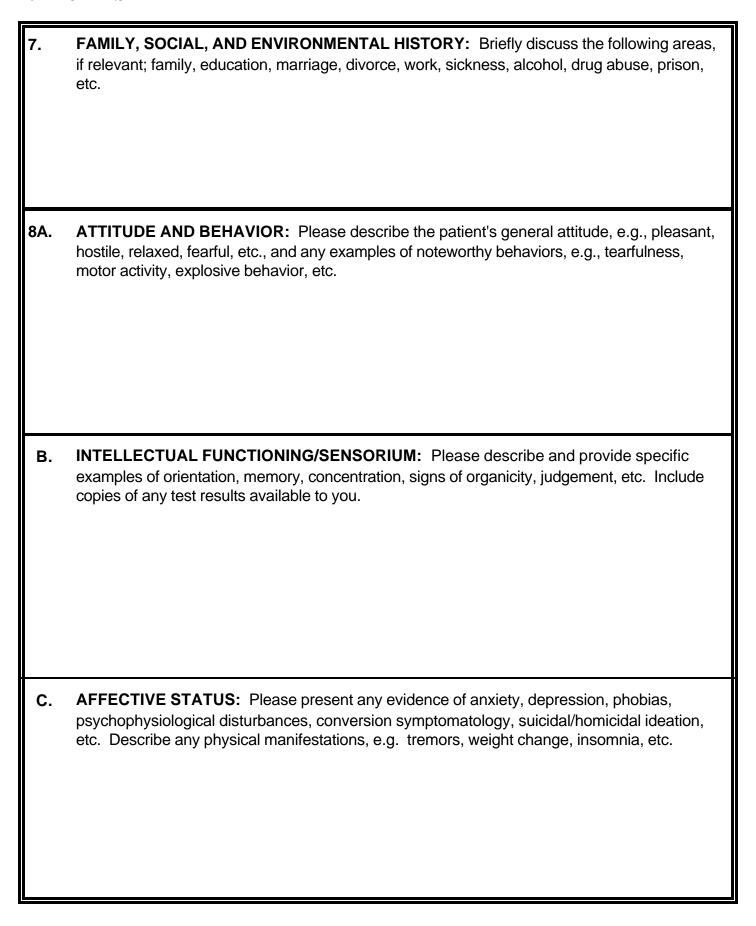
## TO THE WORKER:

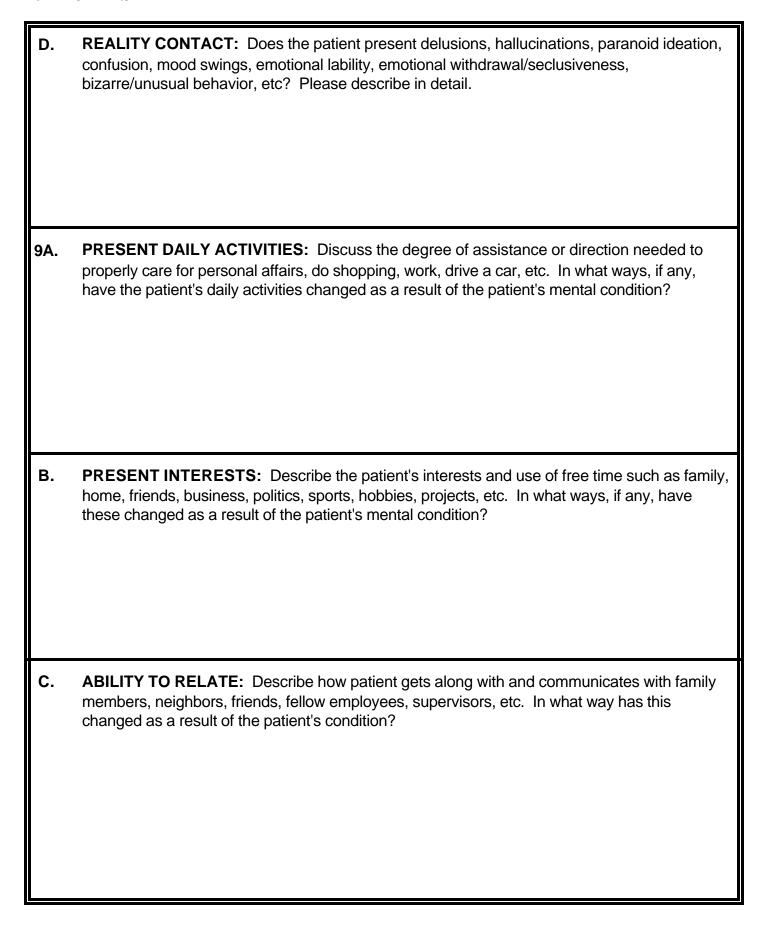
This form should be sent to the person who treats the client for his mental problems.

Please **include a pre-addressed return envelope** that the provider can use to return the completed form/report in. Completed form/report should not be given to the client. Include your name, address and telephone number above, so the provider can contact you if necessary.

Include a completed form **MI 706** Request for Medical Information with the form 20M. The doctor will use the MI 706 for payment purposes. If the doctor requests additional evaluations or testing before completing the form 20M, refer him/her to the instructions and phone number on the back of the MI 706.

1.	Patient's Name	Social Security Number	Client ID#	
2.	Name of Reporting Physician (Printed/Typed)	Title	Phone	
3.	Patient First Examined	Date of Last Examination	Frequency of Visits	
5.	appointments? In what way and by whom? Please describe posture, gait, mannerisms, and general appearance.			
6.	PAST HISTORY OF TREATME location, and course of treatment treatment, Residential Treatment	t. Also describe any outpatient t	-	





D.	<b>PERSONAL HABITS:</b> Describe the patient's grooming, clothing, hygiene, etc. In what ways, if any, have personal habits changed as a result of the patient's mental condition?
10.	MEDICATION: DOSAGE AND FREQUENCY.
11.	DIAGNOSIS:
12.	<b>PROGNOSIS:</b> Can the patient's condition be expected to improve? If so, when do you consider significant change likely to occur?
13.	COMPETENCY: Is patient competent to manage funds on his/her behalf?
14.	ADDITIONAL COMMENTS: Attach additional pages, if necessary.
15.	
	Signature of Physician Date
to be	<b>E: If completed and signed by other than an MD/PhD</b> , an LCSW for instance, the form needs cosigned by an MD or PhD. If copies of previous reports (signed by an MD or PhD) are led, this form would not need to be cosigned.
DO N	OT give the report to the client. Please return the completed report to the worker.